Gender Identity Disorders In Childhood And Adolescence: A Critical Inquiry And Review Of The Kenneth Zucker Research

By the NARTH Scientific Advisory Committee

Published March 2007

The debate continues as to whether or not a diagnosis of gender identity disorder (GID) is wanted or needed today, especially for children. Indeed, some are calling for the complete removal of GID from the DSM (Isay, 1997), with the reasoning that GID is used to pathologize gender-variant children. Others suggest that GID has the potential to derail biological priming and places children at risk for distress. While arguments from both sides of the scientific and political spectrum are likely to persist for some time, this paper seeks to review the work of perhaps one of the more prominent researchers in this area: Dr. Kenneth J. Zucker. Dr. Zucker is Psychologist-in-Chief, Centre for Addiction and Mental Health, Head, Child and Adolescent Gender Identity Clinic, Child, Youth and Family Program—Clarke Division, Toronto, Canada.

Recent Literature on Gender Identity Disorder: A Compilation of Reviews

I. Gender Identity Disorder Overview

Zucker (2005) presented the principal findings of research on children and adolescents manifesting the "sex-typed behavioral patterns that correspond to the diagnosis of Gender Identity Disorder (GID)." This review summarizes three topics in the research literature: diagnosis and assessment, associated psychopathology, and developmental trajectories.

Diagnosis and assessment. Zucker attends to the questions of whether GID can be diagnosed with reliability and validity. Concerning children, the clinical research literature has scarcely addressed the issue of reliability except for a single study (Zucker et al., 1984) which demonstrated that the diagnosis can be reliably made. In addition, the author cites many studies that provide strong evidence for the discriminant validity of GID.

To support this contention of discriminant validity, Zucker describes factor analyses of two psychometric instruments: the 11-item Gender Identity Interview for Children, which was administered to child subjects, and the 16-item Gender Identity Questionnaire for Children, which utilized parent reports. The mean factor scores significantly differentiated subjects from controls, with the factors accounting for approximately 48% and 44%, respectively, of the variance for the two instruments.

In contrast to children, there are relatively few studies investigating adolescents, and none dealing with reliability. The author points out that this dearth of research likely reflects the low numbers of adolescents who are treated for GID.

Zucker contends that the diagnostic criteria effectively differentiate both children and adolescents with GID from "subthreshold cases" because mild gender dysphoria is very uncommon. However, this article also includes a summary of several studies that addressed the question of whether the DSM IV criteria distinguish GID patients from those who merely exhibited "extreme gender nonconforming behavior." The results cited demonstrate that the criteria consistently separate the threshold from the subthreshold cases even when the latter group's effect sizes on gender nonconformity are substantial.

Nevertheless, the author acknowledges that rendering some revisions to the DSM could reduce the future risk of diagnostic error. First, the criteria could be strengthened by mandating that "the repeated stated desire to be, or insistence that he or she is, the other sex" be applied to all patients in order to qualify as GID. Currently, this criterion is listed under a heading in a group of five with subjects needing only to meet four of these in order to achieve a diagnosis. Second, he posits that adding the descriptors of "persistent" and "intense" to some of the criteria listed under cross-gender identification would further screen out those whose gender dysphoria is merely episodic.

Finally, the essential question is addressed of whether GID comprises a true mental disorder or is simply a normal variant that is the object of unnecessary social disapproval. In defending the appropriateness of preserving GID as a diagnosis, Zucker quotes the DSM-III as saying that "there is no satisfactory definition that specifies precise boundaries for the concept of 'mental disorder.'"

In addition, he states that the disjunction of somatic sex from gender identity inherently indicates that a condition of psychological distress is occurring. This is especially the case when one considers the ultimate outcomes of GID as either sex-reassignment surgery or contrasex hormone treatment. Furthermore, he suggests that the desire of certain patients to have a limb amputated because it is experienced as alien to the body, described by some as Body Integrity Identity Disorder, perhaps parallels the sensation in GID patients that their genitals are ego-alien.

Associated psychopathologies. Associated psychopathologies comprise the second topic covered in this review. Here, Zucker points out that several case studies provide evidence of GID's co-occurrence with Pervasive Developmental Disorder. He theorizes from these descriptions that behavioral rigidity and obsessiveness are traits that appear to be common to both disorders, with GID patients particularly manifesting obsessions with issues surrounding gender.

Normative studies present additional evidence about co-morbidity. For example, parent report data reveal that GID children have, on average, more behavioral problems that either their non-referred siblings or other children. Other studies demonstrate that boys with GID have a clear pattern of internalizing behavior problems, such as schizoid traits and withdrawal, and both boys and girls have low ratings of global self-worth and self-perceived social competence.

Behavioral problems in boys with GID increase with age. This is likely at least partly due to the effects of peer ostracism, although research data also indicate these difficulties are associated with a composite index of maternal psychopathology. Thus the tendency of GID boys to internalize may also reflect general familial risk for other mental disorders such as depressive conditions.

Developmental trajectories. In this third section, Zucker makes a distinction between the retrospective and prospective studies of GID as these lead to somewhat differing but complementary interpretations. The author points out that a considerable amount of developmental research has been completed although significant gaps still exist.

The retrospective studies indicate that adults and adolescents with GID almost universally recall patterns of cross-sex identification in childhood. Thus the case for childhood onset is clearly demonstrated.

A particularly important retrospective finding involves adult homosexuals. Here, a meta-analysis of 48 studies in addition to 14 subsequent studies found that both male homosexuals and lesbians were far more likely than heterosexuals to recall cross-gender identification during childhood.

Four prospective studies assessed GID male children, or those with prominent characteristics associated with GID, and evaluated them again at one or more follow up points. Results indicate relatively low rates of GID persistence into adolescence or adulthood, ranging from 2.9% to 20%. The differing figures may be explained by the nature of the respective subject pools, with the lowest figure involving youngsters drawn from a general population, while the remaining studies examined clinic-referred children who likely exhibited more extreme cross-gender traits. With large clinic samples now available, Zucker postulates that it should be feasible to conduct within-group analyses which will lead to the identification of predictor variables discriminating between the persistent and desistent cases of GID.

A noteworthy finding involved the high proportion of subjects reporting a homosexual or bisexual orientation at follow-up. Figures varied from 42.5% to nearly 80%, all far above both those of the control groups as well as the population base rates. Although gender dysphoria did not continue past childhood in the great majority of these cases, adolescent and adult males known to have GID traits as children appear to have strong inclinations toward homosexual or bisexual attractions. With reasons for this correlation unknown, the author recommends this as a major focus of future research.

In contrast to boys, relatively little study has been completed with GID girls. This dearth of research reflects the low incidence of clinic referrals of girls, possibly because GID seems to be the object of less ostracism with girls than is the case with boys.

Nevertheless, published investigations report rates of GID persistence and homosexuality at follow up that are higher than those found with male subjects. Adolescent patients have extremely high GID persistence rates. Three investigations concluded that 43.2% to 66%

of the teens (subjects' genders were not identified) had gender dysphoria that persisted in such a manner as to qualify them to receive either sexual reassignment surgery or a further evaluation that could lead to the scheduling of that procedure.

The consistency of the studies' results is remarkable; GID typically remits when identified in childhood, but most often is persistent when identified in adolescence. The cause for this difference is unknown, but may involve one or both of two possible explanations. One might be referral bias with the children belonging to families showing more concern for the psychological wellbeing of their offspring, compared to the adolescents, who typically received no professional care for GID during childhood.

Alternatively, gender dysphoria may be characterized by more plasticity and malleability during childhood than is the case later on. With adolescence, these traits apparently become more refractory and less amenable to change. Therefore, the evidence suggests that treatment begun during childhood is far more likely to be successful than that conducted during the teen years.

In conclusion, the research conducted to date provides significant evidence that GID can be diagnosed with reasonable certainty, being distinct from less extreme forms of gender dysphoria. GID is associated with psychological problems, particularly in boys, such as internalizing behaviors, and is possibly correlated to maternal mental health problems. Whether they received treatment or not, GID patients are shown to have a high probability of developing a homosexual or bisexual orientation after childhood. If treated during childhood, however, the condition is likely to desist. If untreated, significant distress occurs with patients experiencing their genitals as something akin to being ego-alien and typically seeking drastic measures such as sexual reassignment surgery.

II. Summary Comments about Zucker's (2006) *GID in Children and Adolescents*

Overview of clinical and research literature on *gender identity disorder* (GID) for adolescent males and females with limited attention given to *transvestic fetishism* (TF) for adolescent males (Zucker, 2006).

Terms defined: *Sex* (biological male/femaleness); *Gender* (psychological or behavioral characteristics associated with biological males and females); *Gender Identity* (basic discrimination of males from females and a sense of belonging to one sex); *Gender Role* (behaviors, attitudes and personality traits that a given cultural/historical society designate as more appropriate to masculine/feminine); *Sexual Orientation* (sex- and age- of the persons to whom one is attracted sexually); *Sexual Identity* (who/how one regards oneself to be as a sexual being vs. one's actual attractions and/or behaviors).

Historical Context of GID: From 19th century recognition of adults who suffered profound discomfort with gender identity; to the use in 1923 of "transsexual"; to "gender dysphoria"- "a sense of awkwardness or discomfort in the anatomically congruent gender role and the desire to possess the boy of the opposite sex"; clinically, any experience of being sufficiently uncomfortable with one's "biological sex to form the wish for sex

reassignment." Original focus on males has expanded to research and treat gender dysphoria in females. Relatively new development "is the availability of hormonal and surgical techniques for transforming aspects of biological sex to conform to the felt psychological state." Research on adolescents with GID lags behind research on children and adults.

Developmental Psychopathology Framework: "Adaptational failure must be defined with respect to normative developmental tasks" (Sroufe); "In the general population of males and females…most females have a female gender identity;…a feminine gender role behavioral pattern; and …are erotically attracted to males." The reverse for males.

Description of GID in Adolescents: Strong psychological identification with the opposite sex, verbalization of strong desire to become a member of the opposite sex, and expression of extreme unhappiness about being one's own sex.

Core Symptoms:

1) Frequently stated desire to be a member of opposite sex.
2) Verbal or behavioral expressions of anatomic dysphoria (wanting to masculinize their bodies if female, or feminize them if male).
3) Strong desire to pass socially as member of opposite sex (e.g., changing one's hair, clothing, name).

Diagnostic Criteria (DSM-IV-TR): Criteria for adolescents were differentiated from those for children as thought to be more closely related to indicators seen in adults.
Point A possible indicators of "strong and persistent cross-gender identification":

(1) stated desired to be the other sex.
(2) frequent passing as the other sex.
(3) desire to live or be treated as the other sex.
(4) conviction that s/he has the typical feelings and reactions of the other sex.

Point B possible indicators of "persistent discomfort with [one's own] sex or sense of inappropriateness in the gender role of that sex":

(1) preoccupation with getting rid of primary and secondary sex characteristics.
(2) belief that one was born the wrong sex.

Reliability and Validity of Dx: There have been *no* formal studies of adolescents (vs. children). It is clinically "uncommon…to encounter an adolescent who has only very mild gender dysphoria." Normative data and base rates suggest that "the frequent wish to be of the opposite sex …appears to be extremely low," and "even a periodic desire to become a member of the opposite sex is quite atypical." It was suggested that when DSM is revised, *Point A* indicators should have specific referents made for "persistence or intensity" of cross-gender identification (vs. transient feelings). *Point B* indicators should differentiate whether "partial" or total sex reassignment is sought.

Special Dx Considerations: DSM allows specification about sexual attraction/orientation for "sexually mature individuals". Most adolescents- and adults- with GID who have a childhood onset are sexually attracted to birth sex; while most

adolescents whose GID started in adolescence – e.g., youth with TF- are attracted to opposite sex.

Prevalence and related demographics: GID in adolescents is considered rare, although not well studied. It is *not* true that GID in childhood necessarily persists into adulthood. During childhood boys tend to be referred more frequently, and at an earlier age (roughly 10 months), than girls, but the referral ratio lessens during adolescence (for various suggested reasons -- including the fact that girls are more likely to engage in "masculine" behaviors than boys are "feminine" ones.) "Children with GID are represented in all socioeconomic groups." "GID occurs in both Western and non-Western cultures." In Canada, child patients with GID tended to be proportionately more Caucasian, to speak English as a first language, and to be born in Canada than were adolescents. *Age of onset* for most adolescents with GID was the toddler/preschool years, during which "multiple indicators of cross-gender behavior including the wish to be of the opposite sex" were reported retrospectively. In general, adolescents diagnosed with GID have "a long history of pervasive cross-gender behavior." Exceptions are adolescents with TF and gender dysphoria and those with "an obsession with gender identity in the context of either a preexisting obsessive-compulsive disorder or Asperger's disorder."

Associated Behavior and Emotional Problems: According to studies using parent and teacher versions of the *Child Behavior Check List (CBCL)*, compared with gender-referred children, "gender-referred adolescents had significantly higher levels of behavioral disturbance." When compared with other adolescents who were either not referred for gender related issues or not referred at all, "GID adolescents had…levels of behavioral disturbance comparable to" the adolescents who were referred for other problems, "and considerably higher levels of behavioral disturbance when compared to the non-referred adolescents." This suggests "that the persistence of GID is a risk factor for the intensification of general behavior problems" in adolescence. "It is likely that multiple factors contribute to their difficulties, including risk factors common to many referred youth.

Developmental Course and Outcome: "Regarding psychosexual differentiation [the persistence and desistance of GID], three outcomes have been identified: (1) persistence of GID with a co-occurring homosexual sexual orientation; (2) desistance of GID, with a co-occurring homosexual sexual orientation; and (3) desistance of GID, with a co-occurring homosexual sexual orientation. Outcome (2) has been the most common among boys- with girls not well studied. "From a developmental perspective, *this suggests that gender identity, at least among children with GID, is malleable and likely influenced by psychosocial experiences, such as therapeutic interventions*" (emphasis added here and for subsequent quotes).

Etiology:

Biological: The review of research on the "possible" effects of prenatal hormones, etc., offers lots of conjecture but little substance. And interesting finding, with a poor explanation as to how/why it matters, is that: "Males with GID have an excess of brothers to sisters (sibling sex ratio) and a later birth order. …Males with GID are born late primarily in relation to the number of older brothers, but not sisters.

Psychosocial: with respect to "predisposing, precipitating and perpetuating (or maintaining) factors…Given the early behavioral onset of GID, psychosocial mechanisms that are operative during adolescence are most likely perpetuating or maintaining factors." For example, an intensification of cross-gender identification following "the emerging awareness of homoerotic attractions" probably results from an existing "significant vulnerability in the adolescent's sense of self as a male or female, which is further compounded by having to address sexual orientation issues." Many adolescents with GID grew up in families in which, at least for a time, "cross-gender behavior was tolerated or encouraged, often being viewed as 'only a phase.'" It is hypothesized for adolescents- but so far demonstrated only for children - that "family psychopathology" is a perpetuating factor (e.g., so stressed and burdened by psychiatric difficulties that are less able to address the therapeutic needs of their GID children). Adolescents with GID already are burdened with significantly more general behavioral difficulties than their child counterparts which may make it harder for the adolescents to deal specifically with their gender identity difficulties. *"In fact for many adolescents, the desire to change sex is seen as a way of solving many of their problems in living, which is unrealistic."*

Assessment: While "the development of reliable and valid assessment techniques for adolescents has lagged behind" techniques to assess children, the several which exist "can be used to establish the degree of current gender dysphoria, the extent of both current and childhood cross-behavior, and characterize the adolescent's sexual orientation."

Treatment:

Ethical Considerations: "The politics of sex and gender in postmodern Western culture" raise "complex social and ethical issues" such as is GID "just a 'normal' variant of gendered behavior," and are marked cross-gender behaviors inherently or only relatively/socially harmful. After raising many ethical questions, Zucker advises: "These and other questions force the clinician to think long and hard about theoretical, ethical, and treatment issues.

Developmental Considerations: Since "GID is less responsive to psychosocial interventions during adolescence (and, certainly by young adulthood) than it is during childhood...*the lessening of malleability and plasticity over time in gender identity differentiation is an important clinical consideration.*"

"Therapeutic" Approaches: When GID in adolescence does *not* respond to "psychosocial treatment" (unspecified how that would be attempted), Zucker suggests either that efforts may be taken (e.g., group therapy) to help an adolescent explore and come to make "a homosexual adaptation," or that the otherwise reluctant clinicians may wish to consider offering the persistently dysphoric adolescent the hormonal and surgical interventions used for adults, though these are highly controversial interventions.

Summary Thoughts (by Zucker): Since GID first appeared as a diagnosis in DSM-III in 1980, "*the phenomenology of GID is now well-described and extant assessment procedures are available to conduct a thorough and competent diagnostic evaluation*. …Like other psychiatric disorders that affect adolescents, it is apparent that complexity, not simplicity, is the guiding rule of thumb in any effort to make sense of the origins of GID." Very little research has been done - relative to children or even adults - to identify the "genesis and maintenance" of GID for adolescents. "*The current state of the art suggests a rather poor prognosis for the resolution of GID if it persists into adolescence.*"

III. Measurement of Psychosexual Differentiation: Summary with Reflection

The issues of gender identity, gender role and sexual orientation have been in the forefront of the discussion of human development for some time. Beginning with the work of Money (1957) it was asserted that although biological factors play a role in the development of a gender identity, sociological factors seem to play an even larger role. Diamond (1965) asserted that newborns were psychosexually "neutral" with regard to gender identity differentiation. Implicit in this hypothesis is that malleability in the short run implies adaptation in the long run. It has been demonstrated in the 40 years since that this is not the case- malleability does have a bearing on adaptation in the long run-- namely, that gender atypical behavior and identity is associated with a number of negative outcomes.

The notion of malleability perhaps naively informed physicians that psychosexual surgery, when properly applied, would have positive outcomes for ambiguously appearing children. Money's assertion, particularly with his most famous client, cannot be so simplistically understood and applied as he would wish. Zucker (2005), in his article, argues strongly that clinicians should engage in a formal assessment of children with ambiguous genitalia or gender atypical behavior or identity. The informed clinician (through psychometrics) can better assist other professionals, the parent and the child than merely relying on the assumption of malleability and adaptability.

There are several assumptions that one makes when using psychometrics to assess psychosexual differentiation, and Zucker wishes his reader to be aware of them.

1. Psychometrics should be able to demonstrate differences between a normative and clinical population. These differences should be demonstrable in the three areas associated with
    a. Males and females having a Gender Identity consistent with their gender.
    b. Males and females having a Gender Role consistent with typical gender behavior.
    c. Males and females being erotically attracted to their opposite gender.
2. A second assumption is that even animals on the evolutionary ladder below primates demonstrate that sociological factors play a significant role in the acquisition of gender-typical behaviors. This is used as justification for applying what others might assert are "transient, oppressive, cultural mores" as indicators of either typical or atypical gendered behavior. If animals socialize their young

along certain patterns for the betterment and survival of the species, it is not oppressive, arbitrary or coercive to assess and encourage the socialization of children along those same lines.

3. A third assumption is that psychometric measures should be tied to cultural definitions of the two genders, unless the trait being measured is so demonstrably transient or arbitrary as to be meaningless.

Zucker then begins to list for the reader a variety of instruments which can either be administered to the child or to the parent which have moderate to large Effect Sizes. In this regard they are powerful (they properly reject the null hypothesis that there is no difference between gender-identity disordered children/physically intersex condition and normals). These measurements occur in all three areas of assessment: gender role, gender identity and temperament. This makes the assessment and validity of a GID diagnosis all the more powerful as it occurs in multiple measures across multiple attributes:

> "…all of the measures listed in Table 1 met one or more of the following psychometric requirements: (1) there was evidence for a significant normative gender difference; (2) there was evidence for discriminant validity in comparing children with GID versus controls; (3) there was evidence for discriminant validity in comparing children with physical intersex conditions…versus same-sex controls."

The power of these assessment tools is all the more compelling when one looks closely at the statistical analyses used in these instruments. Each instrument demonstrates moderate to large Effect Sizes (.50 and larger). This is especially true of parent report measures. Even more importantly these effect sizes are larger for GID children than for CAH children (girls with congenital adrenal hyperplasia).

These moderate-to-large effect sizes are present in 11 studies of free play, such that normative children play with gender-typical toys at a much higher rate that either GID boy and girls or CAH girls. Free play that includes both gender typical toys and the opportunity for dress-up seems to be an even more useful tool at discriminating behaviors typical of girls and boys (Rekers and Yates, 1976).

The next question to be addressed in research is the assessment of adults and adolescents along the same three dimensional paradigm (gender identity, gender role, sexual orientation). The concept of how gender identity effects gender role and sexual orientation over time has not been operationally assessed. This leads clinicians to speak to parents, doctors and clients from a vacuum. Although there are a number of assessment tools which are said to address these factors in these age groups, they are inadequate by comparison to the precision of tools which exist to assess children.

Consequently, a lack of empirical data leads to much guessing and assertions based upon religion, politics and other subjective systems which may or may not serve the client. In this regard it leads me to the following set of questions:

1. What percentage of GID diagnosed children later identify as homosexual in orientation?
2. What percentage of GID diagnosed children later continue gender-atypical behavior, but identify with their gender role and do not identify with a homosexual orientation?
3. What percentage of GID diagnosed children later report gender-typical behavior and identification with their gender role and report opposite-sex attraction?
4. How does the ethical clinician navigate this process, not with only children who are GID, but with adults who later report symptoms consistent with a prior diagnosis of GID?
    a. Is gay affirmative therapy likely to help or harm (does it share some similarities to Money's poorly conceived malleability hypothesis)?
    b. Is reorientation therapy likely to help or harm (is emphasizing masculine interests and friends really sufficient in understanding and helping men who have gender atypical interests who wish to live as heterosexuals)?

IV. Zucker Defends the Diagnosis and Treatment of GID

The diagnosis of GID is under attack these days. In separate articles responding directly to critics, Zucker and Spitzer (2005) and Zucker (in press) address differing but related aspects of the controversy. Zucker and Spitzer respond to the accusation that GID was introduced into the DSM-III in 1980 as a backdoor method of replacing homosexuality as a diagnostic category, which had been deleted from the DSM-II in 1973. This claim has been based on the connection between GID in childhood and later homosexuality, as a homosexual sexual orientation without co-occurring GID is the most common outcome for children diagnosed with GID. The authors challenge the assertion of a homosexuality-GID diagnostic swap on a number of grounds, arguing that the GID diagnosis had shown clear clinical utility and met the test of expert consensus. Moreover, they assert that there was no need for another diagnosis to replace homosexuality, as the DSM-III contained the diagnosis of ego-dystonic homosexuality, and subsequent DSM versions have retained the residual diagnosis of sexual disorder not otherwise specified, which includes distress about homosexual orientation as one of its examples. For Zucker and Spitzer, GID is a credible and valid diagnosis that deserves further study rather than inaccurate historical characterizations.

In a separate response to an article by Langer and Martin (2004) in the *Child and Adolescent Social Work Journal*, Zucker (in press) defends the GID diagnosis against a slew of criticisms. Zucker begins by noting that since the mid-1970s he and his colleagues have assessed about 475 children and 300 adolescents referred for concerns about their gender-identity development. Zucker challenges the view of GID as simply a social construction, which has been asserted based on the higher referral rates for boys as opposed to girls. He contends instead that while social factors influence referral rates, one could equally argue that social factors result in a dismissal of gender conflict in girls, whereby greater tolerance for cross-gender behavior in girls results in parents and therapists not taking seriously the possibility of a girl experiencing substantial distress about her gender identity.

Elsewhere Zucker addresses the claim that the distress of the GID child is not inherent to the condition but rather a byproduct of social disapproval. He observes quite cogently that:

> If one considers the developmental adolescent or adult "end-state" of GID, i.e., the strong desire to align the body via contrasex hormones and sex-reassignment surgery….to the felt psychological state, it is difficulty to argue that cross-gender feelings and behaviors simply constitute normative variation or do not constitute an example of impairment. The required physical interventions are simply too radical to be though about otherwise. (p. 14).

Zucker also observed that research indicates children with GID have poorer social relations than controls and evidence a developmental lag in the acquisition of gender constancy. In response to the claim that the GID pathologizing of gender atypicality in boys is misogynistic and reinforces traditional male dominance over women, he questions why in an arguably patriarchal culture a boy would ever want to be a girl and adopt the identity of the oppressed female class. The sociopolitical model of patriarchical oppression should, if anything, predict a predominance of girls who want to be boys rather than the other way around. In addition, Zucker asserts, "There is considerable evidence for cross-cultural similarities in gender dysphoria, including its developmental history and concurrent phenomenology" (p. 17).

Perhaps of most interest to clinicians is Zucker's reply to the assertion that the diagnosis and treatment of GID is harmful to children. He affirms the notion that the diagnosis of GID is not what elicits stigmatization by others, but rather the behaviors that comprise the diagnosis. That is, the behaviors of the GID child are what lead to ostracization by peers, not the diagnostic label. In terms of treatment, Zucker views Langer and Martin's perspective as one of essentialism, meaning that children with GID are born that way and simply need to be left alone. While Zucker perceives gender identity and sexual orientation, especially among males, to become more fixed with age, he believes the data suggest a much greater plasticity in childhood. Consequently, he confesses, "As a result, many clinicians, and I am one of them, take the position that a trial of psychological treatment, including individual therapy and parent counseling, is warranted" (p. 22-23).

Overall, Zucker (in press) is very sympathetic for the need for continued research on the treatment of GID, acknowledging that clinicians at present have to rely primarily on accrued clinical wisdom rather than methodologically rigorous outcome studies. Of course, the ability to continue to study GID treatment is predicated upon its continued existence as a diagnostic condition, something that Zucker is obviously not taking for granted.

V. Girls with Gender Identity Disorder

Although gender-identity disorder (GID) is seen in the human population, it is not typical because most youth do not have it (Zucker, 2006). Clinically seen, children with GID present with a strong preference for sex-typed behaviors of the opposite sex and reject behaviors more characteristic of their own sex. It is best seen as a disorder because according to clinical and standardized assessment data it is subject to malleability with intervention. It is not a fixed state of human variance. Drummond's (2006) thesis supports this suggestion. The study based in Canada provided the data of 25 girls (ages 12 and younger) with GID and found that, after follow up, only 12% were judged to have persistent GID in adulthood or later adolescence. In line with these findings, other outcome studies have shown that the majority of boys with GID are no longer gender dysphoric when they reach adulthood.

It was cited throughout the literature review that GID is highly correlated to psychosexual outcomes of transgenderism as well as homosexuality and bisexuality. In addition, GID is highly associated to high psychosocial comorbities such as: poor relationships, behavioral problems, DSM Axis I and Axis II disorders and self-injurious behaviors.

Conclusion

Zucker's research contradicts the notion that GID is a phantom disorder and that children diagnosed with GID present with no more distress than other children. To the contrary, his research suggests that these children do indeed have more psychological and behavioral problems than non-referred children. In response to an article in the *Psychiatric News* (July 18, 2003) suggesting that not only was GID a phantom disorder but it was the parents' distress, not the child's distress that was problematic, Zucker offered the following response: "Consider, for example, a 3-year-old girl who repeatedly states that she is a boy or that she wants to be a boy. Her parents reply by telling her that she is a girl, and the child's reaction is to cry and insist otherwise. Hill's interpretation of such distress is that it is merely the result of the parents' reaction, not the possibility that the child is also struggling with a complex feeling state. Of course, if the parents went along with the child's fantasy that she was a boy, there would be no overt distress, but it would hardly solve the underlying problem and would merely reinforce it." (Zucker, 2003).

Perhaps, the bigger issue is the rights of parents to oversee the development of their children. If GID is a risk factor for the later development of homosexuality, and GID is a treatable condition, do parents have the right to seek treatment for GID as a means of preventing a homosexual outcome?

Zucker's success in helping children with GID has excellent documented success. In their book, *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents,* he and co-author Susan Bradley conclude: "It has been our experience that a sizeable number of children and their families achieve a great deal of change. In these cases, the GID resolves fully, and nothing in the children's behavior or fantasy suggest that gender identity issues remain problematic…All things considered, we take the position that in such cases a clinician should be optimistic, not nihilistic, about the

possibility of helping the children to become more secure in their gender identity." In spite of the politically sensitive connection between childhood gender -identity disorder and later adult homosexuality, Zucker and Bradley believe treatment of childhood GID can be both "therapeutic and ethical." They base their case on several points, claiming treatment affords the following benefits:

1. A reduction of social ostracism by peers.
2. An opportunity to relieve the psychopathology which has been documented to be associated with GID, both in the child and within the family;
3. The prevention of later transsexualism;
4. The prevention of homosexuality in adulthood. On this controversial point, Zucker believes that treatment is justified for social reasons--but he is doubtful about their being justification to prevent homosexuality for religious reasons.

And if a secure gender identity prevents the development of later homosexuality, as Zucker acknowledges as a possibility, parents should be informed of the research on the relationship between the two. Zucker's priority is "helping these kids be happily male or female," but he also acknowledges that the treatment process does, in some cases, apparently avert homosexual development. And in support of parents' rights to avert a homosexual outcome for their children, Zucker cites a persuasive quote from Richard Green: "The right of parents to oversee the development of children is a long -established principle. Who is to dictate that parents may not try to raise their children in a manner that maximizes the possibility of a heterosexual outcome? It that prerogative is denied, should parents also be denied the right to raise their children as atheists? Or as priests?"

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